

## Coordination of Benefits / Direct Claim Form

See the back for instructions. Complete all information.  
An incomplete form may delay your reimbursement.

*medco*<sup>®</sup>

### Member/Subscriber Information *See your prescription ID card.*

Group No. **PEHP000**

Member ID

Member Name (First, Last)

Street Address

City

State

Zip

### Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year)

Sex *Relation to Card Holder*

- |                                 |                                              |                                               |
|---------------------------------|----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Female | <input type="checkbox"/> 1 Self              | <input type="checkbox"/> 5 Disabled Dependent |
| <input type="checkbox"/> Male   | <input type="checkbox"/> 2 Spouse            | <input type="checkbox"/> 6 Dependent Parent   |
|                                 | <input type="checkbox"/> 3 Eligible Child    | <input type="checkbox"/> 7 Other              |
|                                 | <input type="checkbox"/> 4 Dependent Student | <input type="checkbox"/> 8 Non-spouse Partner |

### Pharmacy Information

Name of Pharmacy

Street Address

City

State

Zip

Telephone (include area code)

Pharmacy NABP/NPI  
Number (required)

### Claim Receipts

Tape claim receipts on the back.

**Do not staple!**

**Check the appropriate box if any of the receipts are for a medication that:**

- Is a compound prescription.  
If so, make sure your pharmacist lists ALL the VALID 11-digit NDC numbers and quantities for each ingredient on the receipt. (See back.)

### Coordination of Benefits

(Another health plan has paid a portion.)

Mark the appropriate box for your primary coverage method. **See the back for more information.**

**Is this a coordination of benefits claim?**

- Yes  No

**Please select how/where the primary claim was paid:**

- Retail pharmacy  
 The Medco Pharmacy/Mail-Order Service  
 Another health plan paid through its medical benefits and you are enclosing an Explanation of Benefits (EOB) that outlines how much you paid and how much the other carrier paid.

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.

**Please tape receipts on the back.**

### Acknowledgment

I certify that the medication(s) described above was/were received for use by the patient listed above, and that I (and the patient, if not myself) am eligible for drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

**X**

Signature of Member

